

Briefing Note

Elected Member Briefing – *Focus on Frailty in Shetland*

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About this Briefing Note

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Date: 08/10/2026

Subject: Focus on Frailty

Public / ~~Exempt~~ / Confidential

if exempt or confidential explain risks and consequences.

Purpose

This briefing note is to provide a summary of the joint NHS and IJB development session held online on 6th October 2026.

The development session set out to share context and learning around the Focus on Frailty work currently underway within the NHS and HSCP in Shetland, and facilitate a conversation around this work. The Focus on Frailty programme is still underway, with a concurrent evaluation phase, and this initial conversation will drive development of a business case about future provision.

Background

Frailty is a health state in which recovery from illness or injury can take longer or be more difficult. It is more common with age, although younger people can also live with frailty. Shetland's older population has grown significantly and is projected to continue growing, increasing the importance of preventing avoidable crisis, maintaining independence and using limited health and care capacity well (there is more detail and context around these demographic changes in the recently discussed Sustainable Model of Adult Social Care work, discussed at IJB).

The local Focus on Frailty programme has been established to bring together improvement work related to management of frailty in Shetland. The Programme has been supported by short term Scottish Government funding in 2025/26, which has been carried over to deliver additional workforce resource in 2026/27. The programme has deliberately treated frailty as a whole-system issue rather than creating a separate specialist service, and has aimed to test

different functions and ways of working to approach frailty management. The work connects existing teams and tests how support can be offered earlier, how people can receive a better response at crisis point, and has also explored how care capacity could be released. The programme is now moving towards evaluation and development of a business case for a sustainable longer-term approach.

Key points

- Frailty is everyone's business. The aim is to organise existing services around people, not to add another layer of referral or create a separate "frailty service", recognising the challenge for individuals when support is not joined up, and they have to re-tell their story.
- The greatest opportunity is to reduce fragmentation of care or support, particularly where people move between services or have several needs at once. Better coordination can reduce duplication, delay and the risk that people fall through gaps.
- The model needs to work across the full frailty pathway: identifying and responding to deterioration before crisis; responding differently when crisis occurs; and helping people recover function and independence while making best use of available care capacity – recognising there are challenges we cannot impact with this work, including social care capacity and workforce supply.
- Success should be judged both by outcomes for individuals and by impact on the wider system. The work needs to target the people and points in the pathway where intervention is most likely to make a difference, recognising there are challenges around finite resource and this must be used appropriately.
- Current fixed-term funding has enabled testing, but it also creates workforce and sustainability risks. The next phase must distinguish the temporary resource needed to test and evaluate from the minimum ongoing capacity needed to maintain effective ways of working.

Current workstreams underway:

Workstream	What it is trying to achieve	Examples shared
Discharge without Delay	Reduce avoidable delay and deconditioning in hospital through earlier, coordinated multidisciplinary working.	Frailty education, the “golden 72 hours”, activity passports, hydration work, improved discharge communication and daily multidisciplinary huddles.
Hospital at Home	Provide hospital-level treatment at home either to avoid admission or support earlier discharge.	Nursing, medical and AHP input, with remote monitoring being tested to extend what can safely be provided at home.
Frailty at the Front Door	Offer rapid OT and physiotherapy input when someone reaches crisis and presents to the Emergency Department or emergency respite.	Immediate joint assessment, equipment, reablement and follow-up at home, aiming to avoid admission or reduce a respite stay.
Community Crisis Prevention	Identify people with mild to moderate frailty earlier and offer coordinated assessment and support before deterioration becomes a crisis.	Proactive contact through Primary Care identification, joined-up OT, physiotherapy, dietetic and pharmacy input, and tests of direct referral from GPs and Social Work.

A number of case studies were shared to help illustrate this work. The case studies presented showed the practical difference that timely, coordinated input can make. Examples included a person assessed by OT and physiotherapy in the Emergency Department and supported home with next-day follow-up; a person in emergency respite who received joint assessment, reablement and support to return home; a Hospital at Home patient who regained mobility and independence after early discharge; and a person identified proactively in Primary Care who improved mobility, transfers and nutrition following coordinated AHP support, resulting in a significant impact on their unpaid carers (family carers).

Next Steps:

- Complete evaluation of the current workstreams, including individual outcomes, activity, system impact, workforce implications and any gaps in evidence.
- Use the learning to develop a business case setting out the longer-term frailty function for Shetland, including the minimum sustainable offer and how it will remain integrated with existing services.
- Clarify which elements should continue, change, stop or spread, rather than assuming that all temporary project arrangements should become permanent.

- Bring the proposed future model and supporting evidence back through the appropriate governance routes for consideration.

Overview

The ambition is not to create another frailty service. It is to deliver a sustainable, coordinated frailty function across existing health, care and community services, so people receive the right support earlier, recover as well as possible after crisis, and remain independent for longer. External, short term funding will not be extended, and there is likely to be a need for some degree of additional resource to deliver an effective function that is fit for the future.

Additional resources shared:

Frailty Return on Investment tool:

<https://www.hisengage.scot/media/5jyomyeu/frailty-roi-supporting-info-v2-april25.pdf>

“Golden 72 Hours” explainer video: [The golden 72 hours of acute illness in people who live with frailty - YouTube](#)

Shetland Partnership Plan evidence papers: [Shetland's Next Partnership Plan – Shetland Partnership](#)

HIS Focus on Frailty national improvement programme support detail: [Focus on Frailty – Healthcare Improvement Scotland](#)

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